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STATEMENT BEFORE

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on

Medicare Managed Care: Payment and Related Issues

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Mr. Chairman and members of the Committee, I am pleased to present the Physician Payment Review Commission's views and recommendations on several issues related to payment under Medicare managed care. Expansion of managed care and introduction of new private health plan options for Medicare beneficiaries present both opportunities and challenges. The Commission has been working closely with congressional committees and staff to provide analysis and recommendations that can help inform your deliberations. Any policy changes should further the goals of ensuring Medicare's financial solvency and beneficiary access to timely, appropriate health care services. Accomplishing these goals, however, creates a tension between setting payments that are high enough to provide access but are also affordable.

Over the past decade, there has been tremendous change in how Americans pay for and receive health care. Pressures to reduce growth in health care spending have created a new awareness among consumers, purchasers, and providers of the tradeoffs that arise when resources are finite. Managed care has grown in part because of purchasers and consumers' willingness to trade limits on choice for lower health costs.

Medicare can learn from the experience of the private sector. In fact, as commercial managed-care penetration grows and managed-care enrollees age into Medicare, it is inevitable that more and more beneficiaries will select this option within Medicare. But it is important to keep in mind that Medicare differs in important ways. First, Medicare managed-care enrollment, while growing, still lags substantially behind commercial enrollment (Figure 1). Second, although managed-care growth in the private sector has been associated with reduced cost growth, under current policy, this does not appear to be the case for Medicare. In fact, some studies suggest that managed care growth *increases* program outlays. Third, the private market encompasses a broader range of plan options than Medicare currently permits, but most individuals with employer-based insurance have only a limited number of plans to choose from.

The debate on Medicare managed care always eventually turns to payment. Changes in payment policy could serve several goals: reducing program spending, encouraging managed-care enrollment

by making the program more attractive to plans in certain markets, and improving equity by reducing the variation in benefits offered by Medicare managed-care plans in different areas of the country. My testimony this morning focuses on these issues and the range of policy options that could be adopted. The challenge facing policymakers is to develop an approach to paying plans that is fair, reduces cost growth, and ensures that beneficiaries have access to appropriate care at a cost they can afford.

My statement begins with some brief background information about Medicare managed care and the issues that will arise as managed care choices expand. I will then sketch out how Medicare now pays managed-care plans and the problems associated with current policy which the Commission and others have identified. Finally, I will talk about the different options that the Congress could take to address these problems (including those included in the Balanced Budget Act passed in the last Congress and the President's recent budget proposal) as well the Commission's recommendations concerning implementation of these options.

MEDICARE MANAGED CARE: PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

As you know, Medicare managed care is growing. By the end of 1996, about 13 percent of Medicare beneficiaries were enrolled in some form of managed care, compared to 5 percent in 1990. Participation by beneficiaries varies widely, with over 20 percent of urban beneficiaries enrolled in managed care, compared to about 1 percent of rural beneficiaries. Although predominantly an urban phenomenon, enrollment rates differ across urban areas. Over half of beneficiaries in Riverside, CA, are in risk plans, for example, while virtually none are in Atlanta and Detroit (Figure 2).

Most plans participate in Medicare through the risk-contracting program. Under a risk contract, plans commit to providing Medicare-covered services to beneficiaries for a fixed monthly payment from the program. There were 241 risk contracts in effect at the end of 1996; 17 more have been added in the last two months (Figure 3).

The availability of risk plans varies widely across the nation. In most urban areas, beneficiaries can choose among several plans, while 80 percent of rural beneficiaries have no plan available. Overall, about two-thirds of beneficiaries are served by at least one risk plan; 25 percent have access to more than four plans (Figure 4).

CURRENT POLICY AFFECTING RISK-PLAN PAYMENT, BENEFITS, AND PREMIUMS

Now let's consider the current policies that determine how much risk plans are paid and the benefits and premiums that enrollees receive. Going over a few of the basics will be helpful in understanding the problems created by these policies.

As a result of current policies and local competitive pressures, there is wide geographic variation in payments to plans, in the benefits available to beneficiaries, and in the premiums that they pay. For example, there is a three-fold difference between the lowest and highest county payment rates (Figure 5). Over 50 percent of 1997 county rates, however, are between $340 and $440. Currently, more than three-quarters of risk plans offer additional eye and ear care, and over half provide prescription drug coverage (Figure 6). By the end of 1996, two-thirds of plans provided benefits beyond those covered by Medicare at no additional charge to enrollees (Figure 7).

Setting Payments and Benefits

Payments, benefits, and premiums are the result of two separate administrative processes, as well as of local competitive pressures.

Process for Setting Plan Payments. Payments are set to reflect local fee-for-service costs. Actual per capita spending is adjusted for differences in the characteristics of local populations. This measure, referred to as the AAPCC, is the expected local cost of caring for a typical beneficiary. Each county's payment is set at 95 percent of the AAPCC. Plans are paid this rate with an adjustment

for the characteristics of their enrollees.

In setting both the local rate and the payment to a plan, adjustments are made to reflect the characteristics that affect beneficiaries' use of health care. The same five risk adjusters are used in both steps: age, sex, welfare status, institutional status, and working status. Separate adjustments are made and AAPCCs calculated for the aged, disabled, and end-stage renal patient populations.

This two-step process of setting a local rate for a typical beneficiary in each county and then adjusting payments to plans based on actual enrollment was designed with two purposes. First, expected spending on managed care should equal that in fee for service less the 5 percent savings. Second, plans should be fairly compensated for the relative risks of their enrollees.

Process for Establishing Required and Optional Benefits. The benefits and premiums that risk plans offer to beneficiaries are set in a second process. Plans submit adjusted community rate (ACR) proposals in which they estimate the cost of providing Medicare-covered services to enrollees based on the costs of serving their commercial population. If Medicare pays a plan more than these estimated costs, then the plan must return the difference to Medicare or to beneficiaries in the form of additional benefits. In practice, all plans opt to provide additional benefits to beneficiaries. The Commission estimates that in 1995, enrollees received additional benefits worth about $42 per month for which they paid no additional premium.

In response to local competition, plans may also choose to offer even more benefits. The ACR proposal establishes the maximum premium that plans can charge for these optional benefits, but plans can choose to waive all or part of this premium. In 1995, enrollees received optional benefits worth about $45 per month for which they paid an average of $18 per month.

CONCERNS ABOUT CURRENT POLICY

The wide geographic variation and volatility in spending for traditional Medicare results in large differences in the AAPCC across counties. These differences in turn affect patterns of managed-care enrollment, premiums, and benefits across the country. They may contribute to the uneven pattern of Medicare managed-care enrollment that I described earlier. And they account, at least in part, for the wide and seemingly arbitrary variation in additional benefits that Medicare beneficiaries receive from risk plans in different markets.

Several factors that could be addressed in legislation contribute to this geographic variation. The most important of these are:

- **Inadequacies of current demographic risk adjusters**. Inadequate risk adjustment results in increased Medicare spending in two distinct ways. First, local rates may overstate the likely cost of a typical beneficiary because the AAPCC reflects only beneficiaries who remain in fee-for-service and who have higher costs than managed-care enrollees (Figure 8). If these beneficiaries are less healthy than those in managed care and their poorer health is not captured by the current demographic adjusters, then expected fee-for-service payments are overstated. This is referred to as base-rate bias. Better adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.

  Second, in addition to the local rate being too high, inadequate risk adjustment results in overpayments to plans for their particular enrollees. Current risk adjusters explain only a small portion of the variation in health care costs among Medicare beneficiaries. A more accurate set of risk adjusters would result in lower payments to plans reflecting their relatively healthier enrollment.

  As I will explain in a moment, the Commission plans to make a series of recommendations concerning risk adjustment in its 1997 annual report to the Congress due on March 31st. Better risk adjusters would make the AAPCC a more accurate reflection of expected outlays

for a typical beneficiary and would reduce some of the variation in payments.

- **Inclusion of earmarked funds**. Medicare makes payments to hospitals for graduate medical education and for serving a disproportionate share of low-income patients. Including these special funds in AAPCC-based rates contributes to geographic variation in managed-care payments. It also raises the question of whether these payments should be passed along to all managed-care plans, since they are targeted to compensate specific hospitals for special circumstances beyond the costs of caring for Medicare patients.

  The Commission has recommended that these funds could be removed from the AAPCC. A related but separate issue is whether teaching and disproportionate share hospitals should receive additional compensation for seeing managed-care enrollees or whether managed-care plans should be compensated an additional amount for teaching or serving low-income patients. The Commission recommends that mechanisms be developed to ensure that hospitals, managed-care plans, and other entities involved in training are paid fairly for these costs.

- **Geographic basis of rates**. Use of counties, which are relatively small geographic units, in setting payments leads to more geographic variation and volatility than may be appropriate. Variation and volatility reflect several factors, such as differences in practice patterns, difference in the health status of local populations, and, at least in some cases, small numbers of beneficiaries. Areas larger than counties would help address problems with the AAPCC and may be more consistent with the notion that managed-care plans serve markets, not counties. Using larger areas, however, loses information about the variation in health status at the county level that contributes to the accuracy of payment. For these reasons, any changes to geographic areas should be accompanied by implementation of better risk adjusters.

It is important to recognize that even if all of these technical issues were resolved, under current

policy, savings from managed-care enrollment can not exceed 5 percent. Because managed-care payments increase in lock-step with Medicare fee-for-service expenditures, cost increases in fee for service drive cost increases throughout the program. Expanding managed-care without increasing outlays may require breaking the link between managed-care payments and fee-for-service expenditures.

PROPOSALS FOR CHANGE

Over the past two years, the Congress and the Administration have been considering how to set Medicare capitated rates that are fair to plans and allow the program to benefit from managed-care efficiencies. Proposals to improve risk-plan payment policies were included in the Balanced Budget Act passed during the 104th Congress. Similar proposals were introduced by Senator Daschle and supported by the Administration last year and were more recently put forward in the President's fiscal year 1998 budget proposal. All of these proposals included provisions previously recommended by the Commission.

There are basically three different ways to reduce the variation in risk-plan payment rates. These approaches could be implemented to achieve budget savings, or could be budget-neutral, focused solely on reallocating payments across areas.

The first approach is to improve the AAPCC. Improving risk adjustment, removing earmarked hospital payments, and changing the geographic basis of the local rate would all result in better estimates of patient care costs, which would differ less across areas. In its 1997 annual report, the Commission will recommend making all of these changes.

A second approach is to unlink risk payments from local spending, using current rates as a starting point for setting new rates. A variety of strategies could be used to set rates which have less geographic variation than those now based on the AAPCC. These include blending current local rates

with national rates, trimming rates through floors and ceilings, and setting new ways to update local rates. Since these approaches begin with the AAPCC, the Commission recommends that if they are adopted, that they be adopted in tandem with the improvements in the AAPCC that I just mentioned.

Finally, current policy could be discarded altogether in favor of market-driven competitive solutions. Under this approach, local market characteristics would be used to set rates, either through some form of competitive bidding or a defined federal contribution for both fee-for-service and risk beneficiaries. This approach would work only in markets with sufficient local competition. It could be adapted to markets with little managed-care penetration if payments are based on the experience of both managed-care and fee-for-service beneficiaries. The Commission has recommended that the Health Care Financing Administration (HCFA) test such alternative methods for setting payments, including competitive bidding and partial capitation.

THE IMPORTANCE OF RISK ADJUSTMENT

Regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, plans will not be fairly paid for enrollees with better or worse-than-average health status (for example those with chronic conditions or functional disability). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for.

The Commission recommends that improved risk adjustment be implemented immediately. Although available approaches are not perfect, they would do a better job than the demographic factors currently used. As a first step, the Commission recommends that Medicare begin to phase-in risk-adjusted payment changes using administrative data. For example, our analyses and those of others would support an approach of paying less for new managed-care enrollees who have lower-than-average per capita costs. (New enrollees now account for 55 percent of Medicare managed-care

enrollees, up from 43 percent in 1993.) Since risk adjustment methods typically underpredict the true variation in costs and selection, improvements such as paying moderately less for new enrollees do not risk over adjusting (that is, paying too little) for individuals with certain characteristics.

Because there are substantial differences among plans in the proportion of new enrollees, this approach would be preferable to an across-the-board cut which would particularly hurt those plans with a large proportion of long-time enrollees or those that provide specialized care for vulnerable populations (Figure 9). The President's budget proposes such a cut, setting local rates at 90 percent of the AAPCC, instead of the 95 percent under current policy. Although this would mitigate the budget impact of risk selection against the fee for service program, it would not adjust for risk selection among managed-care plans and so would not reduce plans' incentives to avoid enrolling costly beneficiaries.

Steps could also be taken immediately to improve the availability of data useful for risk adjustment. For example, hospitals are now required to submit "no-pay" bills to HCFA for hospitalized managed-care enrollees but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

Use of administrative data for risk adjustment is an important first step. Over the longer term, the data and infrastructure required to support risk adjustment should be developed and implemented. This includes obtaining data that more accurately captures risk (such as those obtained from surveys of beneficiaries or encounter data collected by plans and their contracting providers), further development of risk adjustment models, and implementation of adjusted payment rates.

EFFECTS OF CHANGE

The effect of any payment changes on total Medicare payments, plans, and beneficiaries will

ultimately depend upon how they are implemented, how much payment levels change, and how plans and beneficiaries respond. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk plan payments will differ, depending upon the exact combination of policies and the sequence in which they are calculated.

The effects of changes on plan participation and beneficiary enrollment are also uncertain. If plans and beneficiaries are sensitive to payment rates, then rate changes could lead to participation increases in areas with increased rates and declines in those where rates drop. But if plans and beneficiaries are relatively insensitive to risk-plan payment rates, then we might not see such effects.

Unfortunately, there is little information that could guide us in predicting how plans and beneficiaries will react to payment changes. Researchers have been examining this question but their conclusions have been mixed. One recent analysis indicated that plan entry into the risk program is highly sensitive to the local payment rate. Another published study found that beneficiary enrollment rates are much more sensitive to factors such as local managed-care penetration in the commercial market than to local Medicare rates.

If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required in order to make accurate budget projections. In particular, it will be important to understand how beneficiaries of different risk categories select between managed care and fee for service. The Commission has concluded that any changes in payment policy should be designed and phased in so as to reduce disruptive effects on beneficiaries and plans.

CONCLUSIONS

In its March 31st report, the Commission will make a series of recommendations concerning managed-care payment policy, many of which I have already mentioned (Figure 10). It is important

to recognize, however, that payment policy is only one of the factors that will determine the future of managed care within Medicare and its impact on the federal budget, beneficiaries, and providers. Realizing the potential of Medicare managed care will also require policy changes to minimize risk selection. Policies concerning information available about choices, the enrollment and disenrollment process, and enrollee grievance procedures must work together to allow plans to compete effectively and to protect beneficiaries. The Commission has made a variety of recommendations about these topics that I hope will provide the Congress some guidance.

I would also like to take the opportunity to mention that since the vast majority of Medicare beneficiaries remain in fee-for-service (and are likely to do so for the next decade), the Commission has also devoted some time to issues related to improving traditional Medicare's performance. I would be glad to provide information about these issues to the Committee.